

# WISCONSIN DEPARTMENT OF REGULATION & LICENSING



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STATE OF WISCONSIN  
BEFORE THE BOARD OF NURSING

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IN THE MATTER OF	:	
DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	FINAL DECISION AND ORDER
CHRISTINE M. STEWART,	:	LS # 0507146NUR
RESPONDENT.	:	

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Division of Enforcement Case # 04 NUR 313

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Christine M. Stewart, R.N.  
6121 Spring St.  
Racine, WI 53406

Division of Enforcement  
Department of Regulation and Licensing  
1400 East Washington Avenue  
P.O. Box 8935  
Madison, WI 53708-8935

Board of Nursing  
Department of Regulation & Licensing  
1400 East Washington Avenue  
P.O. Box 8935  
Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board of Nursing. The Board has reviewed the attached Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Christine M. Stewart, R.N., (DOB 10/04/1965) is duly licensed as A registered nurse in the state of Wisconsin (license # 135244). This license was first granted on 06/27/2000.
2. Respondent's most recent address on file with the Wisconsin Board of Nursing is 6121 Spring Street, Racine, Wisconsin.
3. At all times relevant to this action, Respondent was working as a registered nurse at Christopher East Health and Rehabilitation Center ("Christopher East") in Milwaukee, Wisconsin.
4. Patient R.P. was a resident at Christopher East. His diagnoses included but were not limited to dementia, delirium, cerebellar degeneration, ataxia, and seizures all secondary to chronic long term alcohol abuse. He was at times combative and agitated.

5. Patient R.P. had difficulty swallowing, and on November 7, 2003, he had a gastrostomy feeding tube inserted.
6. On November 8, 2003, patient R.P. pulled out his gastrostomy feeding tube. Respondent reinserted the tube without orders from a physician to do so.
7. An L.P.N. then called and informed the physician that the tube had come out but had been reinserted. The physician said, "Okay."
8. Later that evening, patient R.P. again pulled out his feeding tube. Again, Respondent reinserted the tube without an order from the physician and without notifying the physician.
9. Still later that evening, Respondent gave patient R.P. a tube feeding and also gave him medication through his feeding tube.
10. Soon after the feeding, patient R.P. became unresponsive and was transported to the hospital by ambulance.
11. At the hospital, it was discovered that when the feeding tube was reinserted by Respondent, it was mistakenly placed so that it led to the peritoneum rather than to the stomach. Respondent died six days later of acute peritonitis.
12. When a gastrostomy feeding tube is less than six weeks old, reinsertion should be completed by surgeons or gastroenterologists in an emergency setting because the tract is not yet formed and leakage into the peritoneum is possible. When a gastrostomy feeding tube is more than six weeks old, reinsertion may be accomplished by an experienced R.N. because by then the tract is formed and reinsertion is relatively simple.
13. When the physician was called about the reinsertion of the feeding tube, he was unfamiliar with the patient and was not told that the feeding tube had just been inserted the day before.

### CONCLUSIONS OF LAW

1. The Wisconsin Board of Nursing has jurisdiction to act in this matter, pursuant to Wis. Stat. § 441.07,[\[smg1\]](#) and is authorized to enter into the attached Stipulation and Order, pursuant to Wis. Stat. § 227.44(5).
2. The conduct described in paragraphs 4-13 above constitutes a violation of Wisconsin Administrative Code §§ N7.03(1)(a) and N 6.03(2) and Wis. Stat. § 441.07(1)(b).

### ORDER

IT IS ORDERED :

1. The license of Christine M. Stewart to practice as a registered nurse in the State of Wisconsin is REPRIMANDED.

IT IS FURTHER ORDERED that:

2. Respondent shall, within 30 days of the date of this Order, submit to the Board Monitor copies of six (6) articles that she has reviewed that deal directly with the care and complications of gastrostomy tube feedings.
3. Respondent shall, within ninety (90) days from the date of this Order, pay costs of this proceeding in the amount of three hundred and fifty dollars (\$350.00). Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

Department Monitor  
Division of Enforcement

Department of Regulation and Licensing  
P.O. Box 8935  
Madison, WI 53708-8935  
Telephone (608) 267-3817  
Fax (608) 266-2264

3. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to pay costs as ordered the Respondent's license(#135244) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order. [\[smg2\]](#)

4. This Order is effective on the date of its signing.

Board of Nursing

By: Jacqueline Johnsrud, RN  
A Member of the Board

July 14, 2005  
Date

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[\[smg1\]](#) This should be deleted/ changed to a blank

[\[smg2\]](#) This section should be the standard summary suspension provision: **Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order.** Where the terms of discipline consist of a forfeiture, costs or continuing education, alternative "self-effectuating" language should be utilized. E.g.: **In the event Respondent fails to timely submit any payment of the forfeiture as set forth above, the Respondent's license(#1550) SHALL BE SUSPENDED, without further notice or hearing, until Respondent has complied with the terms of this Order.**